TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Texas Bone and Joint Center

Respondent Name
Mitsui Sumitomo Insurance Co

MFDR Tracking Number
M4-16-0875-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
December 2, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The Approved Doctors List of the workers' compensation system expired August 31, 2007. Under Official Order No. 3365 of the Texas Commissioner of Workers' Compensation…."

Amount in Dispute: $1,558.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Subject to further review, the carrier asserts that it has paid according to applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 6, 2015 January 27, 2015	Physician Services	$1,558.00	$394.04

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
3. 28 Texas Administrative Code §129.5 sets out the reimbursement for work status reports.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 811 – Charges denied because on this date of service, provider was not on the approved doctor list
   - B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the applicable rule pertaining to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code B7 – "This provider was not certified/eligible to be paid for this procedure/service on this date of service" and 811 – "Charges denied because on this date of service, provider was not on the approved doctor list." The requirement of an "Approved doctor list" was abolished with the enactment of HB7, see the summary found at, https://www.tdi.state.tx.us/wc/dwc/legisupdate.html

   Approved Doctor List (ADL)(§408.023, Labor Code)

   - *Retains the ADL and the associated requirements for non-network doctors **until 9/1/2007** (or an earlier date, if determined by the Commissioner of Workers' Compensation). Network doctors are not required to be on the ADL.*
   - *However, HB 7 requires doctors, including network doctors, to comply with the Division's financial disclosure and impairment rating training and testing requirements.*

   The insurance carrier's denial reason is not supported as the dates of service in dispute are after 9/1/2007. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

2. 28 Texas Administrative Code 134.203 (c) states,

   > To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is (date of service yearly conversion factor).

   The maximum allowable reimbursement will be calculated as follows;

   - Procedure code 76881, service date January 16, 2015, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.63 multiplied by the geographic practice cost index (GPCI) for work of 1.018 is 0.64134. The practice expense (PE) RVU of 0.24 multiplied by the PE GPCI of 1.009 is 0.24216. The malpractice RVU of 0.03 multiplied by the malpractice GPCI of 0.772 is 0.02316. The sum of 0.90666 is multiplied by the Division conversion factor of $56.20 for a MAR of $50.95.
   - Procedure code 99213, service date January 16, 2015, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.97 multiplied by the geographic practice cost index (GPCI) for work of 1.018 is 0.98746. The practice expense (PE) RVU of 1.01 multiplied by the PE GPCI of 1.009 is 1.01909. The malpractice RVU of 0.06 multiplied by the malpractice GPCI of 0.772 is 0.04632. The sum of 2.05287 is multiplied by the Division conversion factor of $56.20 for a MAR of $115.37.
   - Procedure code 73562, service date January 16, 2015, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.18 multiplied by the geographic practice cost index (GPCI) for work of 1.018

is 0.18324. The practice expense (PE) RVU of 0.08 multiplied by the PE GPCI of 1.009 is 0.08072. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.772 is 0.01544. The sum of 0.2794 is multiplied by the Division conversion factor of $56.20 for a MAR of $15.70.

- Procedure code 99080 - 73, service date January 16, 2015. Per 28 Texas Administrative Code 129.5 (i) "Notwithstanding any other provision of this title, a doctor may bill for, and a carrier shall reimburse, filing a complete Work Status Report required under this section or for providing a subsequent copy of a Work Status Report which was previously filed because the carrier, its agent, or the employer through its carrier, asks for an extra copy. The amount of reimbursement shall be $15." This amount is recommended.
- Procedure code 76881, service date January 27, 2015, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.63 multiplied by the geographic practice cost index (GPCI) for work of 1.018 is 0.64134. The practice expense (PE) RVU of 0.24 multiplied by the PE GPCI of 1.009 is 0.24216. The malpractice RVU of 0.03 multiplied by the malpractice GPCI of 0.772 is 0.02316. The sum of 0.90666 is multiplied by the Division conversion factor of $56.20 for a MAR of $50.95.
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3. The total allowable reimbursement for the services in dispute is $394.04. This amount less the amount previously paid by the insurance carrier of $0.00 leaves an amount due to the requestor of $394.04. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $394.04.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $394.04 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		December , 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.